McMaster Children's Hospital

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PEDIATRIC CARDIOLOGY CONSULTATION REFERRAL

***If you are referring for echo only, do not use this form. Please use the Pediatric Echocardiogram Referral form (712663), available: Internally: HHS Policy Library**

Externally: https://www.hamiltonhealthsciences.ca/mcmaster-childrens-hospital/areas-of care/medicine/cardiology-clinic/

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Date: (yyyy/mm/dd) _____

Referring Physician _____

Physician's Signature _____

Phone: _____ (ext) _____

Fax: _____

OHIP Billing Number _____

Patient's M # _____

☐ Interpreter required
→ Language _____

☐ CAS / FACS Involvement – (case manager & contact information)

_____

_____

Parent or Guardian Name: _____ **Email:** _____

Current Medication List: ☐ Faxed with Referral **Current Allergy List:** ☐ Faxed with Referral

Reason(s) for Referral (Please select all that apply)

Murmur: Grade ____ / 6 ☐ systolic ☐ diastolic

Palpitations: ☐ at rest ☐ with exertion

Chest pain: ☐ at rest ☐ with exertion

Syncope: ☐ at rest ☐ with exertion

Pre-syncope: ☐ at rest ☐ with exertion

SOB/dyspnea: ☐ at rest ☐ with exertion

☐ **Kawasaki**: Diagnosis Date _____ (yyyy/mm/dd)

→ Treated with IVIG ☐ Yes ☐ No

If any of the 5 issues listed below apply, details must be included with this referral

☐ Abnormal ECG (strips must be faxed) _____

_____

☐ Known cardiac disease *(specify)* _____

☐ Syndromes/Dysmorphisms *(specify)* _____

☐ Family History of congenital cardiac defects *(relationship and diagnosis)* _____

☐ Family History of sudden death *(relationship, age, cause)*

_____

Details of Referral: (frequency of symptoms and other signs and symptoms) _____

_____

**** Please page the pediatric cardiologist on call if the expected date of appointment is within 1 week ****

Please fax legibly completed form and accompanying documentation, including results of tests already completed, to **905-577-8485**. **Incomplete referrals WILL NOT BE PROCESSED.**

If you have any questions about your referral, please contact: (905) 521-2100 ext. 73974

Confirmation of Appointment Date and Time will be provided to the referring physician. It is the referring physician's responsibility to notify their patient of the details.